

Invoicing for intermediate care facilities for the developmentally disabled

California | Medi-Cal Managed Care

The purpose of this bulletin is to provide instructions and key support contacts for submitting invoices in lieu of electronic claims for services rendered in intermediate care facilities for the developmentally disabled (ICF/DD) including ICF/DD, ICF/DD-H, and ICF/DD-N Homes. In compliance with *All Plan Letter (APL 23-023) Intermediate Care Facilities for Individuals with Developmental Disabilities—Long Term Care Benefit Standardization and Transition of Members to Managed Care* stating, Anthem Blue Cross must allow ICF/DD Homes to submit invoices if unable to submit claims electronically.

To accommodate the ICF/DD Homes who are unable to submit compliant claims digitally, ICF/DD Homes may instead submit invoices to Anthem on the paper form of *CMS-1450*, also known as the *UB-04*. Invoices may only include ICF/DD Home services (stays) rendered on consecutive days for a single member when the procedure code, accommodation code, and revenue code data elements are all the same. Anthem has provided a copy of the *UB-04* form, but additional forms can be purchased through resources found on the NUBC resource page [NUBC Resources | NUBC](#).

Please note that non-contracted providers should submit a copy of the ICF/DD Home’s *W-9* with their claim.

Below are *UB-04* field descriptions and instructions. Pay attention to **required** and **if applicable** fields :

UB-04 field location	Required/optional/not required if application or n/a field for inpatient	Description and requirements
1	Required	Rendering provider name and address - enter the provider name, address, and ZIP code and telephone number this section
2	Required	Pay-to provider name and address - Enter the provider name, address, and ZIP code and telephone number this section.
3a	Optional	Patient control number - This number is reflected on the <i>Explanation of Benefits (EOB)</i> for reconciling payments if populated.

Invoicing for Intermediate Care Facilities for the Developmentally Disabled

3b	Not required	Medical record number - Not required. this number will not be reflected on <i>EOB</i> if populated.
4	Required	Type of bill - Enter the appropriate four-character type of bill code as specified in the National Uniform Billing Committee (NUBC) <i>UB-04 Data Specifications Manual: 065*;066*</i> ; See information below under Bill Type
5	Required	Federal tax number - Enter the Federal tax ID for the billing facility.
6	Required	Statement covers period - Enter the From and Through dates of services covered on the claim if claim is for inpatient services
7	Not required	N/A
8a	Not required	Patient name - Enter patient's name in 8b
8b	Required	Patient name - Enter patient's last name, first name and middle initial if known.
9	Not required	Patient address
10	Required	Patient name - Enter patient's last name, first name and middle initial if known.
11	Required	Patient sex - Use the capital letter M for male, or F for female.
12	Required	Admission date - Enter in a six-digit format (MMDDYY), enter the date of admission. (Note: Should match the <i>from date</i> in line #6)
13	Required	Admission hour - Enter hour of patient's admission.
14	Required	Admission/visit type - Enter the numeric code indicating the necessity for admission to the hospital. 1 - Emergency 2 - Elective
15	If applicable	Admission source - If the patient was transferred from another facility, enter the numeric code indicating the source of transfer. 1 - Non-healthcare facility point of origin 2 - Clinic 4 - Transfer from a hospital (different facility)

Invoicing for Intermediate Care Facilities for the Developmentally Disabled

		<p>5 - Transfer from a skilled nursing facility (SNF) or intermediate care facility (ICF)</p> <p>6 - Transfer from another healthcare facility</p> <p>7 - Emergency room</p> <p>8 - Court/law enforcement</p> <p>9 - Information not available B - transfer from another healthcare facility F - Transfer from hospice and is under a hospice plan of care or enrolled in a hospice program</p>
16	If applicable	Discharge hour - Enter the discharge hour.
17	Required	Discharge hour - Enter the discharge hour.
18-28	Optional	Condition codes - Enter the Medi-Cal Managed Care (Medi-Cal) codes used to identify the condition relating to this bill and affect payer processing.
29	If applicable	Accident state - If visit or stay is related to an accident, enter in which state accident occurred.
30	N/A	N/A
31-34	If applicable	<p>Occurrence codes and dates - Enter the codes and associated dates that define the significant even related to the claim.</p> <p>Occurrence codes covered by Anthem: 01 - Auto accident 02 - No fault insurance involvement - Including auto accident/other 03 - Accident/tort liability 04 - Employment related 05 - Other accident 06 - Crime victim</p>
35-36	Not required	Occurrence span codes and dates
37	Not required	Internal control number/document control number
38	If applicable	Responsible party name and address - Enter the name and address of the party responsible for payment if different from name in box 50
39-41	Required	Value codes and amounts. See information below
42	Required	Revenue code - Enter the 4-digit revenue code for the services provided, for example, room and board, bed hold, leave of

Invoicing for Intermediate Care Facilities for the Developmentally Disabled

		absence. See revenue code information below
43	Required	Revenue description - Identify the description of the particular revenue code in box 42. See revenue code information below
44	Required	Rates. These are the DHCS Medi-Cal posted rates.
45	Required	Service date - Enter the service date in MMDDYY
46	Required	Units of service - Enter the actual number of times a single item was provided for the date of service.
47	Required	Total charges (by rev. code)
48	Not required	Non-covered charges
49	N/A	N/A
50	Required	Payer identification (Name) - Enter Anthem
51	Not required	Health plan ID
52	Not required	Release of information certification
53	Not required	Assignment of benefit certification
54	If applicable	Prior payments - Enter any prior payments received from Other Coverage in full dollar amount
55	Not required	Estimate amount due
56	Required	NPI-Enter NPI number
57	Not required	Other provider IDs
58	N/A	N/A
59	N/A	N/A
60	Required	Insured's Medi-Cal ID - Enter the patient's Medi-Cal ID number
61	N/A	Insured group name
62	N/A	Insured group number
63	If applicable	Treatment authorization code - Enter any authorizations numbers in this section. Member information from the authorization must match the claim.
64	Not required	Document control number
65	Not required	Employer name
66	Required	Diagnosis
67	If applicable	Principal diagnosis code/ Other diagnosis codes - Enter all letters and/or numbers of the ICD-10-CM code for the primary diagnosis including the fourth and fifth digit if present

68	If applicable	Other diagnosis codes - Enter all letters and/or numbers of the secondary ICD-10-CM code including fourth and fifth digits if present. Do not enter a decimal point when entering the code
69	If applicable	Admitting diagnosis code
70	N/A	Patient's reason for visit codes
71	N/A	PPS code
72	N/A	External cause of injury code
73	N/A	N/A
74	N/A	Principle procedure code/date
75	N/A	N/A
76	N/A	Attending name/ID qualifier 1G
77-79	N/A	Operating ID, Other ID
80	If applicable	Remarks
81 CC	Not required	Code-code field/Qualifiers

Bill types

Bill type is a four-digit number based on the NUBC data specification manual.

065 ICF/DD or ICF/DD-H

066 ICF/DD-N

The final digit is based on the following:

- 0- Non-payment/zero claim
- 1- Admit through discharge date
- 2- First interim claim
- 3- Continuing interim claim
- 4- Last interim claim
- 5- Late charge(s) only claim
- 6- First interim claim
- 7- Replacement of prior claim
- 8- Void/cancel of prior claim

Revenue codes

When billing for ICF/DD LTC members, there are some key things to remember on the *UB-04* form:

- Revenue codes for ICF/DD services:

Revenue code	Description
0101	Room and board
0180	Leave of absence, general

Share of cost/member liability

LTC ICF/DD members are responsible for paying their share of cost/member liability to the ICF/DD Home. The ICF/DD Home must indicate the member's share of cost on the UB-04 form by using value code 23 with a \$0.00 or greater dollar amount. This amount will be deducted from the amount paid to the facility. Please indicate the value code and amount in boxes 39-41 of the UB-04 form:

- Always use the value code 23 with a \$0.00 or greater dollar amount when billing all claims.
- Billing every two weeks:
 - **Example:** A member's share of cost/member liability is \$1,000.
 - At the beginning of the month, use value code 23 and member's share of cost/member liability:

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	23	1000 :00				
b						
c						
d						

Billing for the last two weeks - use the value code 23 with \$0.00:

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	23	0 :00				
b						
c						
d						

If there is no share of cost, no information is required.

Accommodation codes

Facilities must bill indicating the accommodation code that is applicable to the ICD/DD claim as this drives the appropriate payment rate for a facility based on the California long-term care Medi-Cal rate for the facility.

The accommodation code value must be preceded with the value code 24 in the value code field.

The following are applicable accommodation codes for ICF/DD services:

Accommodation code	Accommodation code description	Bill as a cent (Box 39-41)
41	ICF/DD 1to 59 beds	\$0.41
41	ICF/DD 60 or more beds	\$0.41
43	ICF/DD leave days 1 to 59 beds	\$0.43
43	ICF/DD, leave days, 60 or more beds	\$0.43
61	ICF/DD-H 4 to 6 beds	\$0.61
62	ICF/DD-N 4 to 6 beds	\$0.62
63	ICF/DD-H 4 to 6 beds, leave days	\$0.63
64	ICF/DD-N 4 to 6 beds, leave days	\$0.64
65	ICF/DD-H 7 to 15 beds	\$0.65
66	ICF/DD-N, 7 to 15 beds	\$0.66

68	ICF/DD-H, 7 to 15 beds, leave days	\$0.68
69	ICF/DD-N, 7 to 15 beds, leave days	\$0.69

Where to submit

The *UB-04 paper* claim should be submitted through Availity Essentials. Visit [Availity.com](https://www.availity.com) to register or log in. Anthem's Payer ID number for Availity is 47198. A paper form of the *UB-04* can also be mailed to:

Claims and Billing
Anthem
P.O. Box 60007
Los Angeles, CA 90060-0007

Additional resources

Contact Anthem's LTSS Liaison team for information on Availity office hours.

LTSS Liaison: AnthemLiaison@anthem.com are available to assist ICF/DD Homes in claims payment inquiries.



Email is the quickest and most direct way to receive important information from Anthem Blue Cross.

To start receiving email from us (including some sent in lieu of fax or mail), submit your information using the QR code to the right or via our online form: <http://anthem.ly/signup-abc-ca>.